STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395537	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ROOSEVELT REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **210102**	**7800 BUSTLETON AVENUE PHILADELPHIA, PA 19152**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey and an Abbreviated survey in response to four complaints, completed on April 20, 2023, it was determined that Roosevelt Rehabilitation and Healthcare Center, was not in compliance with the requirements of 42 CFR part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0602 SS=D		F 0602		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0602 SS=D	Continued from page 1 483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 0602	The facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges are deficient under State and Federal regulations relating to long term care. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal and to challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violations of State and Federal regulatory requirements. Residents R93 and R114 were reimbursed, and both have been educated on requesting assistance of Life Enrichment for purchasing of items. Grievances for the last 30 days will be reviewed for lost monies. All variances will be addressed and noted on the Center audit. Staff will be re-educated on the	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0602 SS=D	Continued from page 2	F 0602	policy for misappropriation of resident property. Social Services / Designee will Audit 10 grievances weekly x 4 weeks then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	

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F 0602 SS=D	Continued from page 3 Based on review of facility policies, review of clinical records, review of facility documents, and staff interviews, it was determined that the facility failed to prevent the misappropriation of resident property for two of 35 residents reviewed (Residents R92, R114). Findings include: The facility's policy regarding abuse, last revised January 2023 , indicated that each resident has the right to be free from misappropriation of resident property and exploitation. It protects the resident by anyone including facility staff, staff from other agencies... any other individual. Review of Resident R93's clinical record revealed the resident was alert and oriented diagnosed with Diabetes (a chronic condition that affects the way the body processes blood sugar) a history of a cerebral vascular accident (stroke) and one sided weakness.	F 0602		

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F 0602 SS=D	Continued from page 4 Information submitted by the facility on December 7, 2022, indicated the resident asked a staff member to order him some Chinese food. The resident gave the staff member cash for his food. The food came to $13.15. When the resident received his food he noticed the bill was higher than expected. The resident realized there were more items ordered that he did not ask for. He asked the Nursing Assistant (NA) if she ordered any food but the NA did not reply. The resident did not offer to pay for her food nor give permission to use his money to order food. Review of Resident R114's clinical record revealed the resident was admitted to the facility on December 1, 2022. The resident is alert and oriented and diagnosed with Diabetes (a chronic condition that affects the way the body processes blood sugar) below knee amputation, and atrial flutter (irregular heartbeat). Information submitted by the facility, dated January 11, 2022, indicated a nurse's aide (NA) took	F 0602		

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F 0602 SS=D	Continued from page 5 money from Resident R114's account. The resident admitted he asked the aide to go to the store for him. After the NA returned from the store, Resident R114 noticed money was missing from his account. The Police were called. The Resident did not file charges and the aide walked out of the building when when she heard the facility asked for a statement. 28 Pa. Code 201.14(a) Responsibility of license. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0602		
F 0623 SS=E		F 0623		

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F 0623 SS=E	Continued from page 6 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Residents R4, R164, R83, R455, R18, R167, R181, R130 and R93 had emergency transfer notices sent to the Office of State Long-Term Care(LTC) Ombudsman. All residents with a facility initiated transfer to hospital from November 2022 to March 2023 will have the transfer notice sent to the Office of State Long-Term Care(LTC) Ombudsman. Re-education was completed with the Social Services Department on the monthly submission of facility initiated transfer notices to the Office of State Long-Term Care(LTC) Ombudsman. The facility Assistant Administrator / Designee will audit facility-initiated transfer notices monthly x 4 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0623 SS=E	Continued from page 7 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	as needed.	

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F 0623 SS=E	Continued from page 8 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=E	Continued from page 9 Based on review of clinical records and staff interview, it was determined that the facility failed to send copies of notice for emergency transfer to the representative of the Office of State Long-Term Care (LTC) Ombudsman for nine of nine residents reviewed (Resident R4, R164, R83, R455, R18, R167, R181, R130, and R93). Findings Include: Review of Resident R4's Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 16, 2022, revealed the resident had an unplanned transfer to the hospital on 12/16/2022. Review of Resident R164's MDS dated January 6, 2023, revealed the resident had an unplanned transfer to the hospital on 1/6/2023. Review of Resident R83's MDS dated January 8, 2023, revealed the resident had an unplanned transfer to the hospital on 1/8/2023.	F 0623		

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F 0623 SS=E	Continued from page 10 Review of Resident R455's MDS dated January 10, 2023, revealed the resident had an unplanned transfer to the hospital on 1/10/2023. Review of Resident R18's MDS dated January 19, 2023, revealed the resident had an unplanned transfer to the hospital on 1/19/2023. Review of Resident R167's MDs dated January 22, 2023, revealed the resident had an unplanned transfer to the hospital on 1/22/2023. Review of Resident R181's MDS dated January 25, 2023, February 5, 2023, and March 14, 2023, revealed the resident had unplanned transfers to the hospital on 1/25/2023, 2/05/2023, and 3/14/2023. Review of Resident R130's MDS dated January 25, 2023, February 11, 2023, and March 29, 2023, revealed the resident had unplanned transfers to the hospital on 1/25/2023, 2/11/2023, and 3/29/2023.	F 0623		

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F 0623 SS=E	Continued from page 11 Review of Resident R93's MDS dated March 6, 2023, revealed the resident had an unplanned transfer to the hospital on 3/6/2023. Interview on April 20, 2023, at 2:00 p.m. with Registered Nurse, Vice President of Growth and Professional Development, Employee E3, revealed the facility failed to notify the ombudsman of unplanned hospital transfers from December 2022 through March 2023. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights	F 0623		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 12 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident R83 care plan has been updated to include interventions after choking incident. Incident reports over the last 30 days will be reviewed. All variances will be addressed and outlined on the Center audit. Licensed staff have been re-educated by the Director of Nursing on the policy for updating care plans with changes in condition. The Director of Nursing / Designee will audit ten care plan for updates after a change in condition weekly for 4 weeks, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0657 SS=D	Continued from page 13 Based on review of clinical records and staff interview, it was determined that the facility failed to review and revise one resident's comprehensive care plan in a timely manner after an incident of choking for one of 35 residents reviewed (Resident R83). Findings Include: Review of Resident R83's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 6, 2023, revealed the resident had diagnoses of dementia (group of symptoms that affects memory and thinking) and mild cognitive impairment. Review of Resident R83's comprehensive care plan dated April 12, 2019, revealed the resident had a nutritional problem related to history of unplanned weight loss and dysphagia (difficulty swallowing). Interventions dated December 15, 2023, included a speech consult. Review of a facility incident report revealed on	F 0657		

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F 0657 SS=D	Continued from page 14 December 15, 2022, Resident R83 had a choking incident during breakfast. Review of the incident report revealed nurse aide, Employee E21, made Licensed Nurse, Employee E19, aware that Resident R83 was choking. Review of a statement by Licensed Nurse, Employee E19, revealed upon arrival to Resident R83's room the resident was coughing and wheezing. Employee E19 immediately started the Heimlich maneuver (first aide procedure used to treat upper airway obstructions) and a small piece of food came out. Continued review of the facility's incident report revealed contributing factors to Resident R83's choking may have been related to the resident eating food too fast or did not chew food thoroughly. Interventions included a temporary diet downgrade and speech consult to evaluate for appropriateness of diet. Review of Resident R83's speech therapy	F 0657		

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F 0657 SS=D	Continued from page 15 consultation dated December 17, 2022, by the Speech Therapist, Employee E20, revealed the resident was on a regular diet with thin liquids at baseline. Upon further assessment, Employee E20 determined that Resident R83 was safe to continue regular solids with thin liquids. Further interventions by Employee E20 revealed Resident R83 may benefit from consuming meals in the dining room to allow for occasional/distant supervision as well as ensuring upright posture for entire meal. Review of Resident R83's comprehensive care plan and Nursing Kardex (electronc medical record system used for summaries and overviews of resident care) revealed the facility failed to update the resident's clinical record, in a timely manner, with interventions recommended by the speech therapist to ensure safe chewing and swallowing. Review of Resident R83's comprehensive care plan revealed the care plan was not revised with recommended interventions until January 25, 2023, status post a second choking incident that occurred	F 0657		

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F 0657 SS=D	Continued from page 16 on January 8, 2023. 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d)(5) Nursing services	F 0657		
F 0677 SS=D		F 0677		

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F 0677 SS=D	Continued from page 17 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Residents R177 and R358 were showered. Resident R62 was provided incontinence care. Shower audits and care of dependent residents will be audited for last 7 days. Variances will be addressed and noted on the Center audit. Staff were re-educated on the policy for resident showering preferences, documentation and incontinence care. The Director of Nursing / Designee will complete ten shower audits inclusive of documentation and ten random observations of incontinence care weekly x 4 weeks, then monthly x 2months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0677 SS=D	Continued from page 18 Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to maintain adequate hygiene for dependent residents for three of 35 residents reviewed (Residents R62, R177, R358). Findings Include: Review of facility policy "Bathing and Showering", revised January 2022, revealed the facility will offer showers and tub baths to residents at least twice per week. Provision and refusals of showers and/or tub baths will be documented in the medical record by the nursing assistant and/or licensed nurse. A resident group meeting was held on April 18, 2023, on the 1st floor at 10:30 a.m. Review of Resident R358's clinical record revealed that the resident was admitted to the facility on April 7, 2023. Resident R358 was noted to be alert and oriented during the group meeting.	F 0677		

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F 0677 SS=D	Continued from page 19 Resident R358 reported during the resident group meeting that he didn't have a shower and would like one. Review of the resident's record revealed that resident R358 shower task didn't have any documentation about the receiving a shower from the admission date of April 7, 2023, to April 18, 2023. The progress notes revealed that his first shower in the facility was on April 20, 2023. Review of Resident R358's care plan initiated on April 7, 2022, revealed resident R358 requires assistance with bathing and showering and should be offered a shower twice per week. Review of Resident R177's clinical record revealed that the resident was admitted to the facility on August 8, 2022, with diagnoses of Hemiplegia and hemiparesis (paralysis of one side of the body), muscle weakness, brain injury, and cognitive communication deficit (difficulty with thinking and how someone uses language). Interview with resident R177's roommate, Resident	F 0677		

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F 0677 SS=D	Continued from page 20 R21, on April 17, 2023, at 1:12 p.m. revealed, Resident R177 has not received a shower in three weeks. Interview with R177 revealed resident nodded and said, "yes," when asked if he wanted a shower. Review of Resident R177's Care Plan initiated on August 29, 2022, revealed resident R177 requires assistance with bathing and showering and should be offered a shower twice per week. Review of resident section, special instructions, in the resident's clinical record revealed Resident R177 "prefers to be showered and to be shaved," and is scheduled for showers on Tuesdays and Fridays on the 3-11 shift for both days. Further review of Resident R177 shower documentation revealed Resident R177 received four showers in the last thirty days (March 21, 2023- April 19, 2023). Resident R177 received a shower on March 22, April 4, April 15, and April 16, 2023.	F 0677		

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F 0677 SS=D	Continued from page 21 Review of progress notes revealed only one documented shower refusal note on March 1, 2023. Further review of the resident's clinical record revealed no documented evidence the resident refused a shower. Interview with Unit Manager, Employee E5, on April 19, 2023, at 12:24 p.m. confirmed the above-mentioned findings. Resident R62 was admitted to the facility on July 13, 2022. His most recent MDS (Minimum Data Set- a periodic assessment of resident care needs) assessment was conducted on March 12, 2023. In section G, functional abilities, it was assessed that the resident required extensive assistance from two or more persons in the areas of toilet use and personal hygiene. On April 17, 2023, at 12:41 p.m., the resident was observed during the lunch meal. At this time, the resident was observed to have limited movement in	F 0677		

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F 0677 SS=D	Continued from page 22 his lower limbs and was wearing only a disposable continence care brief from the waist down and was not covered by a sheet or blanket. The resident had a notable odor of a bowel movement. The resident stated that he had informed staff of his bowel movement when his tray was delivered. He stated that he was told they would change him "after lunch." He further stated that he was uncomfortable, and that he felt "degraded" as he was "forced to eat while sitting in my mess." Staff, who did not identify themselves, entered and exited the room multiple times during this interview, but did not directly address Resident R62 or assist him with continence care. Interview with the Nursing Home Administrator, Employee E1, on April 20, 2023, at 1:45 p.m. confirmed that dependent residents should not be left soiled during meal times. 28 Pa. Code: 211.12(1) Nursing services.	F 0677		

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F 0677 SS=D	Continued from page 23 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (2)(5) Nursing services.	F 0677		
F 0686 SS=G		F 0686		

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F 0686 SS=G	Continued from page 24 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident R455 no longer resides in the center Incident reports for residents with pressure ulcers in the last 7 days will be reviewed. Variances will be addressed and noted on the Center audit. Staff were re-educated on the policy for monitoring, assessing, and prevention of pressure ulcers. The Director of Nursing / Designee will audit risk reporters completed for pressure ulcers. Audits will be completed weekly x 4 weeks and monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0686 SS=G	Continued from page 25 Based on clinical record review, review of facility policy, and interviews with staff, it was determined the facility failed to ensure one of three residents reviewed for pressure ulcers was monitored, assessed and received the necessary services to prevent new pressure ulcers from developing, resulting in actual harm of pressure ulcer development for Resident R455. Findings include : Review of the facility's policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol," not dated stated, "The nurse shall describe and document the full assessment of a pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue. The purpose of the procedure is to provide information regarding identification of pressure ulcer/injury, risk factors, and develop interventions for specific risk factors. Review of Resident R455's clinical record revealed the resident was admitted to the facility on August	F 0686		

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F 0686 SS=G	Continued from page 26 12, 2022, diagnosed with Diabetes Type Two (A chronic condition that affects the way the body processes blood sugar), high blood pressure, Traumatic Hemorrhage of cerebrum (bleeding in the brain) with loss of consciousness, volvulus (a loop of twisted intestine causing bowel obstruction), dementia, a history of falling, and cerebral infarction (stroke). Review of Resident R455's admission Minimum Data Set (MDS an assessment of resident's needs) dated August 19, 2022, revealed a brief interview for mental status (BIMS) was conducted revealing he was cognitively intact, was frequently incontinent of urine and used an ostomy for bowel, needed extensive assistance with 1-2 people for bed mobility, transfers, dressing, toileting, and bathing. Review of Resident R455's care plan revealed a potential impairment to his skin integrity and a potential to develop pressure ulcers related to his fragile skin, impaired mobility, and incontinence, dated August 15, 2022. Interventions included	F 0686		

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F 0686 SS=G	Continued from page 27 weekly preventative skin checks as ordered dated August 15, 2022. Review of Resident R455's Quarterly Minimum Data Set (MDS an assessment of resident's needs) dated November 18, 2022, revealed under Section M - Skin conditions revealed "No" was answered for Does the resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher. Review of Resident R455's physician orders dated August 15, 2022, instructed the nurses to perform weekly skin checks to assess the resident's skin for potential impairment or developing pressure ulcers as delineated in the resident's care plan. Review of Resident R455's nursing progress note dated January 10, 2023, revealed the resident had a deterioration in health. The resident was transferred to the hospital due to abnormal vital signs, fever, low/high blood pressures, increased heart rate, respiratory, weight changes and a "skin wound or ulcer." Review of Resident R455's clinical record	F 0686		

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F 0686 SS=G	Continued from page 28 did not include further wound assessments and/or documentation related to the wound. Review of Resident R455's Weekly Checks revealed the last documented skin check completed by a licensed nurse was on December 23, 2022, 18 days prior to the resident's hospital transfer. Review of Resident R455's hospital notes dated, January 11, 2023, revealed a community-acquired, unstageable pressure injury to the resident's sacrum. The hospital note described the pressure ulcer extending to the resident's bilateral buttocks with 100% nonviable (necrotic) tissue, scant to moderate amount of serosanguineous (yellowish fluid mixed with blood) drainage. The resident was also documented positive for incontinence associated dermatitis (exposure to urine on the skin causing damage and increasing the risks of developing pressure ulcers). The lack of the facility performing weekly skin checks, wound assessments, and/or documentation related to the wound revealed the resident failed to	F 0686		

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F 0686 SS=G	Continued from page 29 receive the necessary services to prevent new pressure ulcers from developing, resulting in actual harm of pressure ulcer development for Resident R455. During the survey, the surveyor requested from the Director of Nursing, the Assistant Nursing Home Administrator, and Registered Nurse, Vice President of Growth and Professional Development, Employee E4 the facility's policy on weekly skin checks, the nursing assessments for the missing weekly skin checks, the nursing assessment when the pressure ulcer was found on Resident R455's sacrum including the date, location, stage, length, width and depth, any presence of exudate or necrotic tissue. The facility failed to provide the surveyor the additional documentation and/or assessments. On April 20, 2023, at 3:30 p.m. Registered Nurse, Vice President of Growth and Professional Development, Employee E4, stated Resident R455 was very sick and needed to go to the hospital, the	F 0686		

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F 0686 SS=G	Continued from page 30 facility did not have time to measure wound. The VP stated she could not answer why the physician orders for weekly skin checks were not completed by nursing or why the pressure ulcer was found at such an advanced stage. The facility failed to ensure one of three residents reviewed for pressure ulcers was monitored, assessed and received the necessary services to prevent new pressure ulcers from developing, resulting in actual harm of pressure ulcer development for Resident R455. 28 Pa. Code 211.5 (f) Clinical Records 28 Pa. Code 211.12 (d) (1) Nursing Services	F 0686		

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F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 32 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Residents R24 and R140 medications were discarded and administered per policy Resident R18 is secured in van during outings. The facility completed a review of risk reporters and resident grievances for the past 30 days. No variances were identified related to medication pass or residents being secured in the van during outings. Licensed staff were re-educated on the policy for storage of medications. Newly hired van drivers will be educated prior to resident transport with competency completed on the Driving Safety Policy and securing residents. The Director of Nursing / Designee will audit ten medication administration opportunities weekly x 4 weeks, then monthly x 2 months. The Director of environmental services will audit 30% of the weekly van transports weekly x 2 weeks, then 25% of the weekly van	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0689 SS=D	Continued from page 33	F 0689	transports monthly x 1 month. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	

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F 0689 SS=D	Continued from page 34 Based on review of clinical records, interviews with resident and staff, review of facility documentation, it was determined that the facility failed to ensure one resident was properly secured as a passenger in his wheelchair using the facility's transportation service. This failure caused an accident/fall with increased pain and mental anguish for the resident (R18). The facility failed to obtain/verify an employee's driving credentials and training requirements to ensure residents' safety. The facility did not ensure medication was properly secured for two residents (Resident R24 and R140) for three of 35 resident records reviewed (Resident R18 R24 and R140). Findings include: Review of Resident R18's Quarterly MDS	F 0689		

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F 0689 SS=D	Continued from page 35 (an assessment of resident's needs) dated, February 7, 2023, revealed the resident was cognitively intact, paraplegic (loss of muscle function in lower half of body), bilateral amputation of his lower extremities, and used a wheelchair for ambulation. Diagnoses included, cancer, anxiety, depression, manic depressive (mood swings) and post-traumatic stress disorder (PTSD is a mental health condition triggered by a terrifying event) and used a suprapubic catheter for urinating and a colostomy for bowel movements. The resident was independent with bed mobility, eating, and personal hygiene and required staff set up or minimal help for other activities of daily living. Review of Resident R18's, Nurse Practitioner (NP) Note dated, November	F 0689		

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F 0689 SS=D	Continued from page 36 29, 2022 indicated it was the resident's request for the NP to visit regarding a fall that occurred on the previous day. The resident reported to the NP that while he was in the transport van for an appointment, he experienced a fall when the van stopped suddenly. The note reports that the resident was complaining of pain to his ribs and spine following the fall. Review of Resident R18's care plan revealed the resident was at risk for falls and interventions included "Transport staff to tighten secure seatbelt prior to transport, dated November 28, 2022. The resident was care planned for acute and chronic pain as of July 31, 2020, related to the resident's diagnosis of malignant neoplasm of the (cancerous tumor) pancreas, multiple endocrine neoplasm	F 0689		

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F 0689 SS=D	Continued from page 37 secondary carcinoid tumor liver, osteoporosis (brittle bones), acute transverse myelitis in demyelination disease (inflammation of the spinal cord) of the central nervous system, and used prescription narcotic medication for pain. Interventions included anticipating the resident's need for pain relief, administer the resident's pain medication as ordered and respond to any complaints of pain. Identify, record and treat my existing conditions which may increase pain and or discomfort due to the diagnosis of cancer, and osteoporosis dated, October 10, 2022. Interview with Resident R18 on April 19, 2023, at 02:08 p.m. stated he was a passenger being driven by the facility's van service. In transit, the van abruptly stopped and the resident said he fell out	F 0689		

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F 0689 SS=D	Continued from page 38 of his wheelchair and "Went flying to the front of the van," The resident explained "There are 5 seat belts that are used to secure him in his wheelchair that secure the chair to the van that are buckled to the van's floor. The van driver only used three out of the five seat belts. I thought the driver would have reported it but she didn't. I realized no one came to see me or see how I was doing that day. So the next day I asked to see the Nurse practioner and told her about the accident. She ordered me x-rays. There wasn't any broken bones, but I had cuts and scrapes all over myself. I was in much more pain than usual and it lasted a very long time. I had most of my pain in my neck and shoulder blades. It brought back horrible thoughts of my PTSD and I couldn't sleep,"	F 0689		

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F 0689 SS=D	Continued from page 39 Review of the facility's policy for Employee Fleet/Driving Safety Policy dated January 1, 2023, indicated the key factor will be the strict compliance to traffic regulations and to ensure safe operation of vehicles. The facility's transportation employees responsible to drive will have Motor Vehicle Record (MVR) checked prior to hire then yearly. All employees must have a valid license. All drivers and passengers are required to use seat belts. We have the right to require employees to submit a drug and/or alcohol test post incident. All incidents should be immediately reported to the supervisor. An evaluation of the employee's driving will be conducted at the time of hire and annually. , On April 18, 2023, at 3:07 pm the Director of Nursing (DON) stated after the	F 0689		

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F 0689 SS=D	Continued from page 40 accident Employee E24 did not report the incident, the facility initially approached her. Review of Employee E24's witness statement the driver stated, "When I locked the residents's wheelchair to the floor brackets, to the best of my knowledge I secured his seatbelt to the wheelchair. When I made an abrupt stop the resident lunged forward and fell on the floor" A request for the employee's driving credentials and training were requested and not received during the remaining of the survey, revealing no documented evidence that Employee E24's received driving training, completed a driving evaluation, nor evidence the employee driving credentials were in standing order.	F 0689		

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F 0689 SS=D	Continued from page 41 On April 17, 2023, at 11:40 a.m., a cup of 5 pills was noted on the bedside table for resident R24. When asked about what the pills were and why they were there, the resident stated that they were her "morning medications," which she preferred to take with tomato juice, and had been waiting until she had some available. The resident then took the pills in the presence of the surveyor before the contents could be verified with staff. During an interview with the director of nursing, employee E2, on April 18, 2023, at 12:47 p.m., she confirmed that medications should not be left at the bedside of residents. On April 20, 2023, at 12:15 p.m., a cup containing three white tablets was noted on the bedside table for resident R140.	F 0689		

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F 0689 SS=D	Continued from page 42 When asked about what the pills were and why they were there, the resident stated that they were her "water pills," which she preferred to take after getting out of bed later in the day to avoid bladder incontinence. Nurse aide, employee E10, confirmed the surveyor observation. During an interview with unit manager, employee E8, at 12:25 p.m. she confirmed that leaving medications at the bedside of residents was inappropriate and constituted a safety risk to residents. 211.12 (d) (1) (2) Nursing services	F 0689		

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F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident R179 weights have been assessed and recommendations updated Resident R71 was seen by Registered Dietitian and diabetic teaching was completed Monthly weights for the current month will be audited. Variances will be addressed and noted in the Center audit. Licensed staff were re-educated on the process for weight changes and high blood sugars; as well as communication to the Registered Dietitian. The Director of Nursing / Designee will complete audits of the resident weights, and blood sugars weekly x 4 weeks, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0692 SS=D	Continued from page 44 Based on review of facility policy, observation of clinical Review of undated facility "Weight Policy" revealed each resident will be weighed by the 10th day of the month. The Registered Dietitian will be made aware of any resident displaying a significant weight change (5% in one month, 7.5% in 3 months, 10% in 6 months) and the dietitian will subsequently review the residents medical record and interventions will be recommended as needed. Interventions that are initiated in response to a weight change will be reflected in the care plan. Review of Resident R179's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 16, 2022, revealed the resident was admitted to the facility on April 22, 2022, and had a diagnosis of malnutrition (lack of sufficient nutrients in the body). Review of Resident R179's comprehensive care plan dated April 25, 2022, revealed the resident had a nutritional problem related to therapeutic diet, abnormal nutrition-related labs, and diagnoses. Intervention dated August 17, 2022, revealed the	F 0692		

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F 0692 SS=D	Continued from page 45 resident had history of refusing to be weighed. Review of Resident R179's clinical record revealed the resident was weighed on May 2, 2022, at 174.6 pounds. Further review of Resident R179's clinical record revealed no documented weights for June, July, or August 2022. Review of Resident R179's entire clinical record revealed no documented evidence the Registered Dietitian or physician were made aware of monthly weight refusals. Review of Resident R179's July 2022 meal intakes revealed staff failed to consistently document and monitor resident intakes. Review of Resident R179's August 2022 meal intakes revealed staff failed to consistently document and monitor resident intakes. Review of Resident R179's clinical record revealed no follow-up from the Registered Dietitian between	F 0692		

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F 0692 SS=D	Continued from page 46 from April 2022 until August 2022. Review of nutrition assessment by Registered Dietitian, Employee E26, dated August 19, 2022, revealed Resident R179's weight of 174.6 pounds (from May 2022) was favorable for age. Further review of the assessment indicated the resident had variable intakes and that the resident reported not eating most of meats offered during meals due to chewing difficulties. Continued review of Resident R179's clinical record revealed a documented weight on September 14, 2022, of 156 pounds, which would have reflected a significant weight loss of 10.6% and 18.6 pounds over 4 months. Review of Resident R179's clinical record revealed the significant weight change was not addressed by the Registered Dietitian, Employee E12, until September 30, 2022. Review of Registered Dietitian, Employee E12's weight change note revealed the significant weight loss was unplanned	F 0692		

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F 0692 SS=D	Continued from page 47 and that the Registered Dietitian would follow-up upon reweight obtainment. Review of Resident R179's entire clinical record revealed no documented evidence a reweight was obtained. Review of R71's Comprehensive MDS dated March 31, 2023, revealed the resident was admitted to the facility October 18, 2021, and had a diagnosis of diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R71's care plan dated October 22, 2021, revealed the resident had a nutritional problem related to controlled carbohydrate diet (helps people with diabetes keep their carb consumption at a steady level). Further review of Resident R71's care plan dated February 12, 2023, revealed the resident had diabetes mellitus. Interventions dated February 12,	F 0692		

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F 0692 SS=D	Continued from page 48 2023, included dietitian consult as needed, and to monitor and document signs and symptoms of hyperglycemia (elevated blood sugar levels, above 180 to 200 milligrams per deciliter (mg/dl)). Review of Resident R71's blood glucose history from March 30, 2023, through April 20, 2023, revealed the resident's average blood glucose level was 303 mg/dl (ranging from 136 mg/dl - 581 mg/dl). Review of Resident R71's clinical record revealed a change in condition assessment dated April 10, 2023, by the Director of Nursing, Employee E2, that the resident was transferred to the hospital for hyperglycemia, blood sugar of 581 mg/dl. Interview with Resident R71 on April 18, 2023, at 11:30 a.m. revealed the resident complained of consistently high blood sugar levels. During a follow-up interview with Resident R71 on April 19, 2023, at 1:15 p.m. the resident reported	F 0692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0692 SS=D	Continued from page 49 the facility sends foods that increase blood sugars. Resident R71 reported that she had received no nutrition education for diabetes management. Review of Resident R71's entire clinical record revealed no documented evidence the Registered Dietitian was consulted related to the resident's high blood sugars levels and subsequently no documented evidence diabetes nutrition education was reviewed with the resident. 28 Pa. Code 211.5 (f) Clinical records 28 Pa. Code 211.6 (d) Dietary services 28 Pa. Code 211.12 (c)(5) Nursing Services	F 0692		
F 0695 SS=E		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395537	A. BLDG: 00 B. WING:	04/20/2023

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F 0695 SS=E	Continued from page 50 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident R130's oxygen order was clarified and the tubing was changed and dated. Resident R71's oxygen order was clarified. Resident R95 had nebulizer tubing and treatment disposed of and issued another one, placed in bag, and dated. All residents currently using oxygen and nebulizer treatments were audited. Variances were addressed and noted on the Center audit. Licensed staff were re-educated on the policy for respiratory treatment tubing replacement, labeling and physician orders. The Director of Nursing / Designee will complete audits of resident respiratory tubing, labeling and physician orders weekly x 4, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0695 SS=E	Continued from page 51	F 0695	Improvement Committee monthly for further review and recommendations as needed. Report findings at least quarterly to the QA committee	

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F 0695 SS=E	Continued from page 52 Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to ensure resident's received respiratory therapy in accordance with physician orders and standards of professional practice for five of 35 residents reviewed (Resident R130, R71, R95, R164, and R195). Findings Include: Review of undated facility policy "Oxygen Administration" revealed staff should verify and review the physician's orders for oxygen administration. Review of Resident R130's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 14, 2023, revealed the resident was readmitted to the facility on April 4, 2023, and had diagnoses of chronic obstructive pulmonary disease (chronic inflammatory lunch disease that causes obstructed airflow from the lungs), and chronic respiratory	F 0695		

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F 0695 SS=E	Continued from page 53 failure (lungs are unable to get enough oxygen into your blood) with hypoxia (low levels of oxygen in the blood). Further review of the MDS revealed the resident was cognitively intact and used oxygen therapy. Review of Resident R130's physician order summary revealed an order dated April 4, 2023, for continuous oxygen at 2 liters/minute via nasal cannula. Further review of physician orders dated April 7, 2023, revealed the oxygen tubing should be changed weekly. Interview on April 17, 2023, at 11:42 a.m. with Resident R130 revealed staff never change the oxygen tubing. Observations revealed the resident's oxygen tubing had no date to indicate the last time it was changed. Further observations revealed the resident's oxygen was running at 4 liters/minute. Interview with Resident R130 revealed 4 liters is baseline and what was used at home. Interview on April 17, 2023, at 2:00 p.m. with	F 0695		

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F 0695 SS=E	Continued from page 54 licensed nurse, Employee E5, confirmed Resident R130's oxygen was running at 4 liters and was going to clarify the physician order. Further interview confirmed the resident's oxygen tubing was not dated. Review of Resident R71's comprehensive MDS dated March 31, 2023, revealed the resident had diagnoses of chronic obstructive pulmonary disease and respiratory failure with hypoxia. Further review of the MDS revealed the resident was cognitively intact and used oxygen therapy. Review of Resident R71's physician order summary revealed an order dated July 15, 2022, for continuous oxygen at 2 liters/minute via nasal cannula. Observations on April 18, 2023, at 10:30 a.m. revealed Resident R71's oxygen was running at 3 ½ liters/minute. Interview with Resident R71 confirmed this is what the oxygen concentrator should be set to.	F 0695		

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F 0695 SS=E	Continued from page 55 Further observations on April 20, 2023, at 11:15 a.m. revealed Resident R71's oxygen was still running at 3 ½ liters/minute. Interview on April 20, 2023, at 11:18 a.m. with licensed nurse, Employee E15, confirmed Resident R71's oxygen was running at 3 ½ liters/minute. Continued interview with Employee E15 revealed at night the resident's oxygen runs at 3 ½ liters due to increased anxiety (sense of uneasiness, distress, or dread) and during the day it is brought back down to 2 liters/minute as indicated in the physician orders. Further interview with Employee E15 confirmed the physician order only reflects oxygen administration of 2 liters/minute and that the employee is going to further consult with respiratory staff. Observations conducted by two surveyors on April 17, 2023, from 11:20 a.m. through 12:10 p.m. revealed the following:	F 0695		

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F 0695 SS=E	Continued from page 56 The nebulizer tubing and administration equipment for Resident R95 was undated, and was laying on his bedside table, uncovered by a bag. The nebulizer tubing and administration equipment, as well as the oxygen tubing for Resident R164 was undated. The nebulizer tubing and administration equipment for R195 was labeled with the date April 5, and was laying on his bedside table, uncovered by a bag. Interview with employees E1 and E2 on April 19, 2023, at 2:30 p.m. revealed that these findings do not represent appropriate care and management of respiratory therapy equipment. 28 Pa. Code 211.12 (d)(1) Nursing services 28 Pa. Code 211.12 (d)(5) Nursing services	F 0695		

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F 0730 SS=D	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Employee E16, E17, and E18 had their annual performance review completed. All nurse aides had an annual evaluation done. The Human Resources Director has been re-educated by the facility Administrator on the policy for yearly performance reviews. The Human Resource Director/designee will complete random annual performance review audits of 10 nursing assistants weekly for 2 weeks, then monthly for 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0730 SS=D	Continued from page 58 Based on review of facility documentation and interviews with staff, it was determined that the facility failed to complete performance reviews for three of three nurse aides reviewed (Employee E16, E17, and E18). Findings Include: Review of Employee E16's submitted employee documentation revealed the nurse aide was hired on 04/28/2008. Review of Employee E17's submitted employee documentation revealed the nurse aide was hired on 10/02/1989. Review of Employee E18's submitted employee documentation revealed the nurse aide was hired on 05/21/1985. Review of available documentation revealed no performance review evaluations were available for review for the above nurse aide staff.	F 0730		

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F 0730 SS=D	Continued from page 59 Interview on April 20, 2023, at 2:30 p.m. with the Director of Nursing confirmed annual performance evaluations were unavailable. 28 Pa Code 201.19 Personnel Policies and Procedures	F 0730		
F 0741 SS=D		F 0741		

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F 0741 SS=D	Continued from page 60 483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by:	F 0741	R18's care plan was updated to reflect interventions related to PTSD and Trauma informed care. The facility completed an audit of current resident care plans for those identified with a diagnosis of PTSD and/or trauma related injury. Variances will be addressed and noted on Center audit. Licensed Nursing Staff and Social Services have been re-educated by the Director of Nursing on the policy for trauma informed care and services. The Social Services / Designee will complete an audit of 5 resident care plans for residents with a diagnosis of PTSD or trauma related injury weekly x 4 weeks, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0741 SS=D	Continued from page 61	F 0741	as needed.	

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F 0741 SS=D	Continued from page 62 Based upon observation, review of clinical records, interviews with a resident and staff determined the facility failed to ensure a resident with a history of trauma and PTSD received the care and services necessary to reach and maintain the highest level of mental and psychosocial well being for one of 35 resident records reviewed (Resident R18). Finding includes: Review of Resident R18's Quarterly MDS (an assessment of resident's needs) dated, February 7, 2023, revealed the resident was cognitively intact, paraplegic (loss of muscle function in lower half of body), bilateral amputation of his lower extremities, and used a wheelchair for ambulation. Diagnoses included, cancer, anxiety, depression, manic depressive (moods swings) and post-traumatic stress disorder (PTSD is a mental health condition triggered by a terrifying event) and used a suprapubic catheter for urinating and a colostomy for bowel movements. The resident was	F 0741		

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F 0741 SS=D	Continued from page 63 independent with bed mobility, eating, and personal hygiene and needed set up or minimal help from staff for other activities of daily living. Review of Resident R18's clinical record revealed a care plan for acute and chronic pain related to the resident's diagnosis of malignant neoplasm of the (cancerous tumor) pancreas, multiple endocrine neoplasm secondary carcinoid tumor liver, osteoporosis (brittle bones), acute transverse myelitis in demyelination disease (inflammation of the spinal cord) of the central nervous system, chronic pain syndrome and used narcotic medication for pain. Interventions included anticipating the resident's need for pain relief and administer the resident's pain medication as ordered. Continue review Resident R18's care plan revealed interventions to alleviate and manage his PTSD, that included encouraging the resident to express his anger and help him gain control, help identify sources of emotions to manage his outbursts dated August 3, 2020. Interventions for the resident's	F 0741		

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F 0741 SS=D	Continued from page 64 behaviors and fixation related to his daily medication and regiment initiated on December 2021, included giving the resident as many choices about his care as possible and to seek staff when agitated and provide the resident with a calm environment to reduce his anxieties when anxious, dated November 2022. Observed on April 17, 2023, at 12:15 p.m. during the surveyor's interview with Licensed Practical Nurse (LPN) Employee E5, Resident R18 interrupted the conversation and asked the LPN for his pain medication. He appeared anxious and said he needed them so he could go downstairs. The LPN sounded annoyed, reminding the resident, "You're not the only one around here!" After the LPN's comment the resident appeared more upset, raised his voice, and hollered at the LPN, "It is a narcotic!" and threatened "I'm going to write you up!" The nurse also raising her voice told the resident "Go ahead and write me up!" The LPN hollering back at Resident R18 appeared to have escalated the resident's frustrations. Interview with Register Nurse, Employee E4, on April 18, 2023, at	F 0741		

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F 0741 SS=D	Continued from page 65 10:00 a.m. stated after the incident she spoke to Resident R18, he told her the LPN made him upset because he wanted his pain medication. Interview with Resident R18 on April 19, 2023, at approximately 12:00 noon, stated the LPN got him upset but he gets upset a lot with the nursing, "They don't know what kind of pain I'm in, and it's a struggle to get my pain medication. When I ask for it I already anticipate having a hard time getting my medications. The facility did not ensure the care approach for mental health delineated in Resident R18's plan of care for behaviors, and PTSD were followed, failing to give the care and services necessary for the resident to reach and maintain the highest level of mental and psychosocial function. 28 Pa. Code 211.5 (f) Clinical Records 28 Pa. Code 211.12 (d) (3) Nursing Services	F 0741		

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ROOSEVELT REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **210102**	**7800 BUSTLETON AVENUE PHILADELPHIA, PA 19152**

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F 0741 SS=D	Continued from page 66	F 0741		
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	R114 had no ill effects from this event. The facility completed an audit for the last seven days for residents receiving prn pain medication. Variances were addressed and recorded on the facility audit tool. Licensed nursing staff were re-educated by the Director of Nursing on the policy for pain management and non-pharmacological interventions. The Director of Nursing / Designee will complete an audit of 10 residents who received prn pain medications weekly x 4 weeks, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0757 SS=D	Continued from page 67 Review of clinical record for Resident R114 revealed the facility failed to ensure one resident's drug regimen was free from unnecessary drugs for one of 35 resident's records reviewed (Resident R114). Findings include: Review of the facility's policy for Pain-Clinical Protocol dated October 2022 indicates the physician will order appropriate non-pharmacological and medical nterventions to address the resident's pain. Pain medication should be selected based on pertinent treatment guidelines. An analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk medications. Review of Resident R114 clinical record revealed he was admitted on December 1, 2022, diagnosed with high blood pressure, Diabetes mellitus, absent of left leg below the knee, absent right foot ,and dehiscence of amputated stump.	F 0757		

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F 0757 SS=D	Continued from page 68 Physician orders for pain management included medications: Gabapentin Tablet 800 MG Give 1 tablet by mouth every 12 hours for PAIN started on December 1, 2022. HCl External Gel 4 % (Lidocaine HCl) Apply to affected areas topically two times a day for hand pain for 14 Days started on April 3, 2023. Tramadol HCl Tablet 50 mg. Give 1 tablet by mouth every 12 hours for pain started on December 2, 2022. Acetaminophen Tablet 325 mg. Give 2 tablet by mouth every 6 hours as needed for General Discomfort. Total Dose 650 mg started on December 1, 2022. Oxycodone HCl Tablet 5 mg. Give 1 tablet by mouth every 6 hours as needed for pain started December 1, 2022.	F 0757		

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F 0757 SS=D	Continued from page 69 Lidocaine External Gel 4 % (Lidocaine) Apply to lower back topically two times a day for pain started on April 7, 2023. Lidocaine External Gel 4 % Apply to Right shoulder topically two times a day for pain started on April 7, 2023. Review of Resident R114's care plan for pain related to impaired skin integrity, neuropathy, surgical amputations status post diabetic ulcer since December 2, 2022, revealed interventions to encourage the resident to try non- pharmacological interventions for pain relief as applicable e.g. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound. Review of the April's record for oxycodone 5 mg tablets revealed no documented evidence non-pharmacological interventions were attempted prior to administration.	F 0757		

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F 0757 SS=D	Continued from page 70 28 Pa. Code 211.12(d)(5) Nursing Services	F 0757		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 71 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Resident R44 medication was discarded and a new one was opened and dated immediately Resident R181 two medication pens were discarded, and replaced. Resident R82 inhaler was discarded and new one dated. Over the counter medications that were found without a date were discarded and new medications were ordered. Resident R185 liquid medication was discarded and a new one was opened and dated. Medication carts were audited to validate all open medications are dated. Variances were addressed and recorded on the facility audit tool. Licensed staff will be re-educated by the Director of Nursing on the policy for labeling and dating medications. The Director of Nursing / Designee will complete an audit of medication carts and medication storage areas weekly X 4 weeks, then monthly X 2 months. Further audit frequency will	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0761 SS=D	Continued from page 72	F 0761	be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	

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F 0761 SS=D	Continued from page 73 Based on review of facility policy, observation, and interview with staff, it was determined that the facility did not ensure that drugs and biological agents were stored properly for two of six medication carts reviewed (2 North, and 2 South Central Nursing Units). Findings include: Review of facility policy "Administering Medications," undated, revealed that "The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container," and "Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident." Review of facility policy "Storage of Medications," undated, revealed that "The nursing staff is responsible for maintaining medication storage and	F 0761		

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F 0761 SS=D	Continued from page 74 preparation areas in a clean, safe, and sanitary manner," and "Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." Review of manufacturer instructions for the storage and use of glargine insulin revealed "Only use your pen for up to 28 days after its first use. Throw [it] away ...after 28 days, even if it still has insulin left in it." Observations of the 2 North medication cart conducted in the presence of Employee E11, Licensed Nurse, on April 20, 2023, at 12:23 p.m. revealed that the following medications were improperly labeled with resident names and/or open dates. Multi use over-the counter medications including, but not limited to, vitamin D3 tablets, aspirin 81mg chew tablets, acetaminophen 325mg tablets, bismuth solution, Geritussin syrup and Clearlax powder were opened, but were not labeled with the date when they were opened. A glargine insulin pen dated "3-10" was found with no name	F 0761		

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F 0761 SS=D	Continued from page 75 label. A lispro insulin pen for R44 was undated. Two NovolinN insulin pens for R181 were undated. Observations of the 2 South Central medication cart conducted in the presence of Employee E9, Licensed Nurse, on April 20, 2023, at 11:45 a.m. revealed that the following medications were improperly labeled with resident names and/or open dates. Multi use over-the counter medications including, but not limited to, vitamin C tablets, magnesium oxide tablets, simethicone tablets, aspirin 81mg chew tablets, acetaminophen 325mg tablets, bismuth solution, Geritussin syrup and Clearlax powder were opened, but were not labeled with the date when they were opened. A fluticasone/solumedrol inhaler for resident R82 was opened and undated. Liquid Keppra solution for R185 was opened and undated. Interview with Employee E1, Administrator, and Employee E2, DON, on April 20, 2023, at 2:30 p.m. confirmed that these medications should all have been labeled with the opened date, and that	F 0761		

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F 0761 SS=D	Continued from page 76 not doing so was not appropriate practice for medication storage. They also confirmed that insulin should be disposed of within 28 days of its opening, and that all single patient medications, such as insulin, should be labeled with the name of the resident to whom they are prescribed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(1)(2)(5) Nursing services.	F 0761		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 77 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	The roast beef identified, was discarded immediately Product substitution was approved by the registered dietician All food is handled according to, "Food preparation and service, rapid cooling procedure" currently in place Culinary staff were educated on "Food preparation and service, rapid cooling procedure" Culinary staff and or designee will audit weekly x then monthly x2.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0812 SS=F	Continued from page 78 [illegible]	F 0812		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 79 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident R187 has room signage per policy on room door and PPE is utilized when working with resident in-room Resident R40 no longer resides in the center All residents with current isolation orders have room signage per policy and PPE in place All residents with current PICC lines were audited to ensure infection control practice per policy related to IV maintenance. Variances were addressed and outlined on the facility audit tool. Staff were re-educated on the policy related to infection control and personal protective equipment including hand hygiene, signage and maintenance of IV sites and administration sets. The Director of Nursing / Designee will audit residents on isolation, staff PPE use, and maintaining IV sites and administering IV medications weekly x 4 weeks, then monthly x 2	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0880 SS=D	Continued from page 80 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	

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F 0880 SS=D	Continued from page 81	F 0880		

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F 0880 SS=D	Continued from page 82 Based on observation, review of facilty policies and staff interview, it was determined the facility failed to maintain proper infection control practices to help prevent the development of and transmission of communicable disease and infections for two of 35 resident records reviewed (Residents R40 and R187). Findings include: Review of the facility's policy for Clostridioides difficile (C diff - is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon)) is to implement Contact Precautions for the prevention and control of C.diff. The facility will ensure that staff are knowledgeable of and adhering to proper use of Contact Precaution which includes performing hand hygiene before donning a gown and gloves. Donning gown and gloves before entering the affected patients room. Doffing gown and gloves and performing hand hygiene prior to exiting the affected patients' room.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 83 Review of Resident R187's clinical record revealed a diagnoses of C. diff and physician orders dated March 28, 2023, to follow the protocol for contact isolation regarding C. diff. Observed on April 17, 2023, at 11:00 a.m. in Resident R187's room with Licensed Practical Nurse, Employee E5, and Nursing Assistant (NA), Employee E25, did not perform hand hygiene and don a gown and gloves before entering Resident R187's room and there was no notice or sign directing visitors. On April 17, 2023, at 11:30 a.m. the NA was observed emptying Resident R187's Foley catheter and did not wear protective equipment. Employee E25, NA, stated she was told to only wear a gown if she will be touching the resident's "Pooh". Review of facility policy titled "Administering Medications," undated, revealed that "Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of	F 0880		

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F 0880 SS=D	Continued from page 84 medications, as applicable." Review of documentation for resident R40 revealed that she was admitted to the facility on March 31, 2023, with diagnoses including, but not limited to, bacteremia (a bacterial infection), and methicillin resistant staphylococcus aureus (a bacteria which causes illness, and which cannot be treated with penicillin or other antibiotics like it). Further review revealed that the resident had an active order for "Vancomycin HCl Intravenous Solution (Vancomycin HCl), Use 750 mg intravenously two times a day for Bacteremia for 20 Days," to be started on April 1, 2023, and completed on April 20, 2023. Review of the Medication Administration Record for resident R40 during April 2023, revealed that the resident had orders for "IV: (PICC) [Peripherally Inserted Central Catheter, a method of intravenous access in which a long, thin tube is inserted into the arm and extends into the larger veins near the heart.] Change Transparent Dressing	F 0880		

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F 0880 SS=D	Continued from page 85 on Admission and then every 7 days; Caps to be changed during dressing change ... one time only for 1 Day on Admission," which was scheduled to be completed on April 1, 2023. This order was discontinued on April 18, 2023. The scheduled dressing change was not signed out as being completed. Continued review revealed that a new order had been placed on April 19, 2023, which stated "IV: (PICC) Change Transparent Dressing on Admission and then every 7 days; Caps to be changed during dressing change. every day shift every 7 day(s)." The dressing was scheduled to be changed on April 19, 2023. Observation of the PICC access site for resident R40 on April 17, 2023, at 11:46 a.m. revealed that the site was covered with a TSM dressing which was dated April 12, 2023. The resident stated that this was the only time the dressing had been changed, and that it was only done because she had complained of redness and pain at the site. The	F 0880		

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F 0880 SS=D	Continued from page 86 insertion site was not visible, as it was obscured by a white square located under the TSM dressing. The dressing was visibly soiled and becoming detached from the arm. Observation of IV Vancomycin administration for resident R40 was conducted at 9:15 a.m. on April 18, 2023. Licensed nurse, employee E11 entered the room and introduced herself to the resident. After preparing the Vancomycin bag, she discarded the old bag and tube, hung the new bag on the pole and inserted the tubing into the bag. She then removed the cap from the resident's PICC line hub (where the tubing attaches to the patient) and cleaned the hub with an alcohol preparation pad. She then laid the hub on the bed to finish preparing the medication and tubing. Observation of the PICC site revealed the resident's dressing was still soiled and unchanged. After preparing the medication and tubing, employee attached the tubing to the resident's hub and restarted the medication. The hub was not cleaned	F 0880		

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F 0880 SS=D	Continued from page 87 again before attaching the tubing. Observation on April 19, 2023, at 11:00 a.m. revealed that the resident's dressing was still soiled and unchanged. Interview with the Administrator and thr DON on April 19, 2023, at 2:30 p.m. confirmed that employee E11 did not maintain appropriate infection control measures when she failed to clean the hub after it had touched the resident's bed. They further confirmed that the resident's dressing should have been changed more frequently, and that any dressing changes should have been documented in the MAR. Observation of resident R40 on April 20, 2023, at 10:27 a.m. revealed that the resident's PICC line and dressing had been removed and a new dressing placed over the site. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		

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F 0880 SS=D	Continued from page 88	F 0880		
F 0919 SS=D	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, review of clinical record, facility [illegible] did	F 0919	Residents R117, R4, R108, received tap bells. The facility completed an audit of current residents and confirmed that all other residents had call bells in working order. No additional variances were noted. Nursing Staff were re-educated on the policy related to call bell access by the Director of Nursing. The Director of Nursing / Designee will complete 10 random audits 5 times per week of call bell function weekly for 4 weeks, then monthly x 2 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: 05/17/2023 Status: APPROVED Date: 05/12/2023

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F 0921 SS=D	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	The identified ceiling tiles were secured in the residential area in the hallway outside the kitchen, in the bathroom located in hallway outside the kitchen, kitchen entrance, main cooking area, and dishwashing area. The facility completed an audit of ceiling tiles. Variances were addressed and recorded on the facility audit tool. Plant Operations Staff were re-educated by the Plant Operations Director on the identification, reporting, and repair of ceiling tiles. The Plant operations director will complete 10 random audits of ceiling tiles weekly for 4 weeks then monthly for 4 months. Further audit frequency will be determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0921 SS=D	Continued from page 90 28 Pa Code 207.2(a) Administrator's responsibility	F 0921		
F 0925 SS=E		F 0925		

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F 0925 SS=E	Continued from page 91 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	R113, R40, R24, R305, R90, R71 resident rooms and kitchen were treated by pest control. The facility completed an audit of the skilled nursing center and confirmed that no other residents had concerns regarding pests. The facility contacted the contracted pest control provider to complete a facility assessment and treatment plan update. The results of that visit were recorded on the visit report. Staff were re-educated on the policy for pest control and the completion of the Pest Control Log for any variances. The Director of Plant Operations will complete a random audit of 10 resident rooms weekly X 4 weeks, then monthly X 2 months. Kitchen Audits will be completed 3 x per week for 2 weeks and monthly x 2 months. The Administrator will review all resident grievances weekly for 4 weeks and monthly x 2 months. Further audit frequency will be	Completion Date: **05/17/2023** Status: **APPROVED** Date: **05/12/2023**

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F 0925 SS=E	Continued from page 92	F 0925	determined by audit findings. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed.	

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F 0925 SS=E	Continued from page 93 Based on resident interviews and observations, it was determined that the facility failed to maintain an effective pest control program for the main kitchen and two of six nursing units (Nursing Units 4 South, and 2 North) Findings Include: Review of facility grievance summary revealed on February 2, 2023, Resident R133 reported to licensed nurse, Employee E23, that a roach came up on his lunch tray. Observations on April 17, 2023, at 11:46 a.m. revealed ants on the floor in the room of resident R40. The resident stated that there had been multiple incidents of having "bugs" in her room, and that she found this "disgusting." Observations on April 17, 2023, at 11:37 a.m. revealed ants on the overbed table for resident R24. The resident stated that there are roaches, ants, and mice "everywhere," and that she sees them "all the	F 0925		

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F 0925 SS=E	Continued from page 94 time." Interview on April 18, 2023, at 10:08 a.m. with Resident R305 the resident complained of mice in room coming out at night. Interview on April 18, 2023, at 10:20 a.m. with Resident R90 at 10:20 a.m., the resident complained of mice and roaches in their room. Resident R90 reported there had been a mouse behind his bed and the nurse aide was afraid to come into the room. Observations on April 18, 2023, at 10:25 a.m. revealed an open container of chocolate chip cookies, not in a sealed, airtight container, left on the dresser of room 409-A. Interview on April 18, 2023, at 10:30 a.m. with Resident R71 the resident complained of mice and roaches in their room. During a follow-up tour of the main kitchen tour on	F 0925		

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F 0925 SS=E	Continued from page 95 April 18, 2023, at approximately 1:02 p.m. observations revealed a cockroach by the surveyor's foot. Food Service Director, Employee E7, confirmed this finding. 28 Pa. Code: 207.2(a) Administrator's responsibility	F 0925		

Certified End Page

ROOSEVELT REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 210102

SURVEY EXIT DATE: 04/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

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